2006-2007 Funding Guidelines
North Carolina Bioterrorism Hospital Preparedness Program Grant

I. Overview

In 2002 the North Carolina Office of Emergency Medical Services (NCOEMS), under Phase II of the Health Resources and Services Administration (HRSA) National Bioterrorism Hospital Preparedness Program (NBHPP) Grant, was directed to develop a "Statewide Needs Assessment" and regional Disaster Response Plans. NCOEMS utilized the existing trauma infrastructure to meet the deliverables set forth by the US Department of Health and Human Services (HHS). The 2003-2004 and 2005-2006 HRSA Grants funding was designated to focus on healthcare facilities meeting pre determined Critical Benchmarks to evaluate preparedness efforts and included decontamination, isolation, and CBRNE education for all healthcare professionals. The 2006-2007 federal grant guidance no longer addresses critical benchmarks, but rather addresses meeting Medical Surge performance measures set up within the Department of Homeland Security Target Capabilities List by Tiers. The Tiered System consists of six levels and specifies local, countywide, regional, state, interstate, and Federal capabilities. (See Tiered Response System document on NCOEMS HRSA Grant web page). NCOEMS is responsible for tiers 4 and 5, and the Regional Advisory Committees (RACs) are accountable for tiers 1, 2, and 3.

II. Funding Methodology

The methodology for distribution and use of the National Bioterrorism Hospital Preparedness Program (NBHPP) funding for North Carolina has changed significantly for the 2006-2007 funding cycle. Grant funds will be distributed to the eight RACs via the lead hospitals to support projects and programs that will specifically address medical surge capacity. The current federal grant guidance no longer addresses critical benchmarks, but rather addresses a Tiered Response System:

- ➢ Tier 1 - Local Entities
  - Examples: Hospitals and EMS Systems
- ➢ Tier 2 - County Response
  - Examples: State Medical Assistance Teams (SMAT) III, local Health Departments, Community Health Centers (CHC), Rural Health Centers
- ➢ Tier 3 - Intrastate Regional Response
  - Examples: Interoperable Communication Systems, SMAT II, Mobile Medical Facilities, Regional, Burn Capability, Mutual Aid Agreements, Regional Laboratories, Public Health Regional, Surveillance Teams (PHRST)
- ➢ Tier 4 - Statewide Response
  - Examples: Community College Initiative, SMAT I, Poison Control Center, Long Term Care, Multi-Hazard Threat Database
- ➢ Tier 5 - Interstate Regional Response

Examples: FEMA Region 4, Emergency Management Compact
- ➢ Tier 6 – Federal Response
  Examples: Incident of National Significance

The majority of previous years grant funds have been directed to tiers 1 and 2 through contracts with hospitals and EMS systems. ***The primary focus of funding this year should be targeted towards tier 3, Regional Response.*** A detailed description of the Tiered Response System can be found on the NCOEMS HRSA Grant web page.

III.   Interim National Preparedness Goal and the Target Capabilities List

On March 31, 2005, the Department of Homeland Security (DHS) issued the *Interim National Preparedness Goal* (the Goal). The Goal establishes a vision for national preparedness including National Priorities. The *Target Capabilities List* (TCL) identifies 37 capabilities integral to Nation-wide all hazards preparedness, including acts of terrorism.

The Goal and the TCL establish a common planning framework in which agencies at all levels of government and across all disciplines can operate. This framework serves to guide agencies and their constituents in appreciating their unique contributions while working toward a goal shared by all. This new strategic framework provides the Nation with an opportunity to begin viewing programs that have traditionally been managed within one particular agency or discipline in a more holistic and connected manner. Only when programs are managed and implemented through an interdisciplinary and multi-jurisdictional approach can the Nation truly begin to operate in the coordinated fashion that an incident of national significance will demand.

This planning method is especially pertinent to the implementation of preparedness grant programs in the *Department of Homeland Security* (DHS) and the *United States Department of Health and Human Services* (HHS). DHS and HHS have made available grant and cooperative agreement funds to States and local jurisdictions to assist in building and sustaining national preparedness through several major grant programs, including:

1. National Bioterrorism Hospital Preparedness Program, Health Resources and Services Administration: HHS
2. Homeland Security Grant Program, Office of Grants & Training (G&T): DHS
3. Public Health Emergency Preparedness Cooperative Agreement: *Centers for Disease Control and Prevention* (CDC)

IV.   Scenario Based Planning

The completed State and County Hazard Vulnerability Assessment should be reviewed and analyzed for identification of specific response capability needs. In addition, the results of your HRSA 2005 - 2006 Hospital Preparedness Survey, should be reviewed and utilized to determine any gaps in capabilities within the applicants region. Performance Measures should be addressed by each region per the Target Capability List Medical Surge section. In addition to developing capabilities for vulnerabilities identified in the State and County HVAs and HRSA Grant Survey, RACs must build their capability to effectively respond to the following three scenarios:

1. Pandemic Influenza (PF)
2. Explosive Event (EE)
3. Inclement Weather (IW)

V.   Regional Approach to Planning

This regional approach will require close coordination with State and Local Public Health Directors, State and County Emergency Management, Law Enforcement, NC Office of Emergency Medical Services, other State and County agencies as appropriate, Community Health Centers, Rural Health Centers, private medical providers and especially the other RACs.

It is imperative that all levels of the medical response and care systems in the RAC are continually exercised and drilled to identify gaps or weaknesses so they can be addressed and strengthened. Hospitals, EMS Systems, Community Health Centers, and Rural Health Centers must adopt an Incident Command System (ICS), continually train and exercise employees on ICS and to incorporate ICS into their emergency response systems. In addition, hospitals and other healthcare providers should collaborate with their local and regional Emergency Managers. Exercises should be done in conjunction with other response agencies and organizations to best judge the entire response system as well as to leverage their funding sources.

VI.   Capabilities Based Planning

Implementing a shared approach to achieving national preparedness requires the Nation to re-orient its programs and efforts in support of the *National Preparedness Goal* (Goal). The Goal establishes a vision for preparedness, identifies Target Capabilities, provides a description of each capability, and presents guidance on the levels of capability that Federal, State, local, and Tribal entities will be expected to develop and maintain. Capabilities-based planning is a process by which to achieve the Goal and the capabilities it outlines. Capabilities-based planning is defined by the Goal as, "planning, under uncertainty, to provide capabilities suitable for a wide range of threats and hazards while working within an economic framework that necessitates prioritization and choice." This planning approach assists leaders at all levels to allocate resources systematically to close capability gaps, thereby enhancing the effectiveness of preparedness efforts.

At the heart of the Goal and the capabilities-based planning process is the TCL. To ensure that the proper capability is being addressed and gaps identified, the State and County HVAs and HRSA Grant 2005 - 2006 Survey need to be applied to the scenario with the greatest threat associated with it. Capabilities-based planning is illustrated in Figure 1.
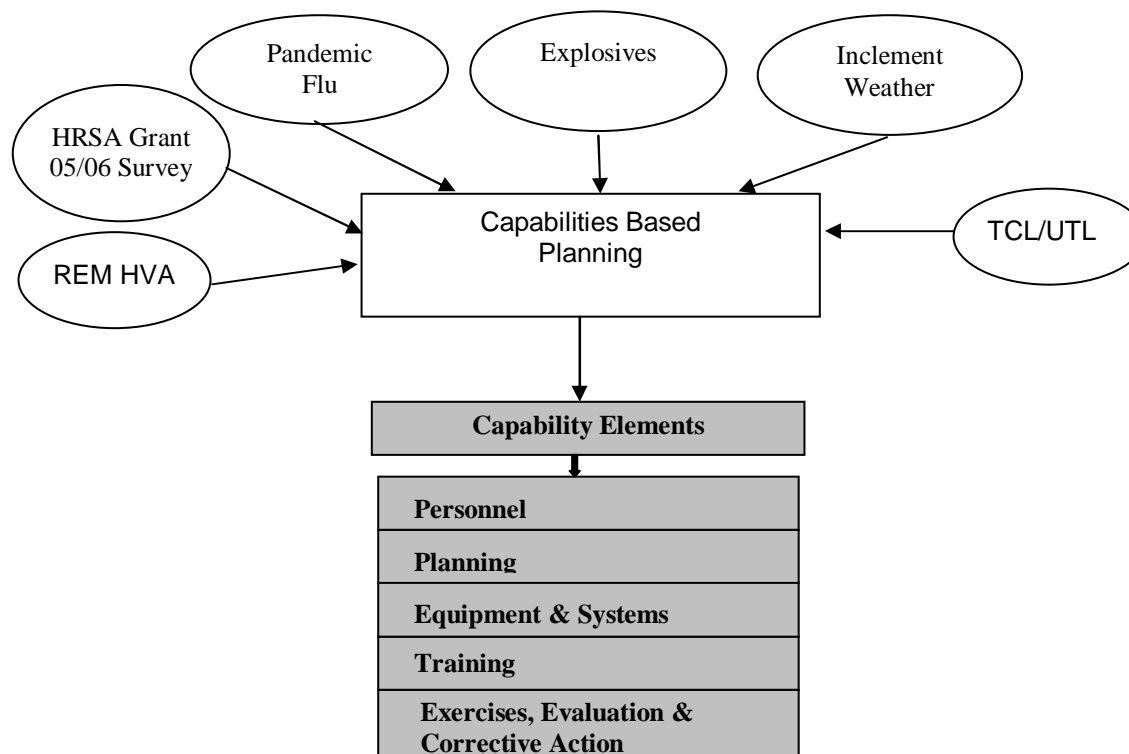
Figure 1
Capabilities Based Planning

Capabilities-based planning will provide a means for your region to achieve the Goal by answering three fundamental questions:

1. How prepared do we need to be?
2. How prepared are we?
3. How do we prioritize efforts to close the gap?

The capabilities-based planning process makes significant use of the TCL which provides additional levels of detail on the underlying tasks and resources for achieving these capabilities. The TCL Draft Version September 2006, Medical Surge Capability pages 495 to 511 can be found on the NCOEMS HRSA Grant webpage. In this document you will find the Critical Tasks and Performance Measures to assist you in developing your grant projects. Capability-based planning necessitates the prioritization of resources and initiatives among the various capabilities. Given limited time and resources, you will be expected to target your planning efforts on the most critical capability gaps. The expectation will vary based upon the risk and needs of hospitals, EMS systems, and other healthcare entities in your RAC. The State and County HVAs and the results of your HRSA Grant 2005 - 2006 Survey will drive the capabilities needed by the RAC's healthcare entities. For

example, a community with a toxic chemical manufacturer must utilize the State and County HVAs, measure the potential health consequences of a chemical release and develop/acquire the capabilities needed for the health system response to the specific consequences.

VII. Capability Elements

In each application, the RACs will describe what currently exists in terms of the flexibility of these tiers to address three scenarios: pandemic influenza, explosive event and inclement weather. In addition to addressing the system flexibilities that will change to meet the three different scenarios, awardees should also incorporate the differences needed for the following capability elements:

1. Personnel
2. Planning
3. Equipment & Systems
4. Training Exercises,
5. Evaluation & Corrective Action

The capability elements and their associated components are defined below:

1. **Personnel –**EMAC/MRC/Other volunteers/Medical Advance or Strike Teams

2. **Planning –** Mobile Medical Facilities/Mass Fatality Plans/Evacuation Plans/Medical Surge Plans

3. **Equipment and Systems –** Decontamination/Isolation/Pharmaceutical Caches/Interoperable Communications/PPE/Hospital Labs Transportation of Special Medical Needs Populations during an event that requires mass evacuation.

4. **Training –** Competency based

5. **Exercises, Evaluations and Corrective Actions –** Entities within the RAC will have to demonstrate their capabilities through State and intrastate regional and local exercises.

For each of the capability elements there are a number of components associated with that element that must be addressed in the RAC grant application. For each project that the RAC intends to complete using HRSA grant funding, the RAC must show in its application:

➤ That not only the capability element and its associated components are eligible for funding but they must be clearly linked to a State or County HVA or HRSA Grant 2005 - 2006 Survey gap analysis to show that there is still an unmet need.
➤ Each capability element and its associated components must be linked to the specific TCL's Critical Task that it is addressing
➤ Each capability element and its associated components must be linked to the specific tier that it is addressing.

Each RAC will develop their projects based on their State or County HVAs or HRSA Grant 2005 - 2006 Survey, the Medical Surge Capacity from the TCL, the three scenarios, the capability elements and their associated components and the medical surge capacity section of their regional disaster plan.

It may be beneficial to the RACs, local entities, and counties to develop projects that will have a significant regional impact, e.g. fewer specific projects for individual counties and hospitals, and larger projects that will positively impact regional response and recovery. This will provide for the most efficient administration of the grant funds and have the greatest impact on regional response and recovery.

VIII. Steps for Completing Application

➢ *Step 1*

Each RAC must convene a Disaster Preparedness and Response Grant Committee (DPRGC). The DPRGC should reflect the composition of the RAC and at a minimum will include representatives from a rural, trauma center, a rural and urban EMS System, any State or Veterans Administration hospitals in the RAC, a Community Health Center, a Rural Health Center, a private practice physician, Tribal community (if applicable), county Emergency Management, a 911 Center, a Public Health Regional Surveillance Team (PHRST) within the RAC, and a representative from the Emergency Management Branch Office. The goal of the DPRGC should be to be as inclusive as possible. While it is essential to include all entities involved in emergency preparedness, this particular grant is not intended to provide funding to fire and law enforcement services unless they are part of EMS system response in providing medical surge capacity. The Regional Hospital Preparedness Specialist and Regional Manager from NCOEMS shall be notified of any DPRG Committee or sub-committee meetings.

Regional Managers & Hospital Preparedness Specialists

Eastern Regional EMS Office	Central Regional EMS Office	Western Regional EMS Office
Keith Harris	**Michael Cobb**	**Danny Harbinson**
Regional Manager	**Regional Manager**	**Regional Manager**
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When determining which projects are to be completed in grant year 2006-2007, each RAC must address the Medical Surge Capability section in the TCL (Pages 495 to 511). The projects must then indicate to which Critical Task it is addressing, how the Critical Task relates to one of the three scenarios (Pandemic Influenza (PF), Explosive Event (EE) or Inclement Weather (IW)), to which tier (1, 2, or 3) it is applicable, and to which capability element(s) the project supports (Personnel (PER), Planning (PLN), Equipment & Systems (EQ/SYS), Training (TRNG) or Exercise, Evaluation & Corrective Action (EE&CA)).

Example: The DPRGC determines that a study is required to determine the effectiveness of the mutual aid agreements within the RAC in the event of a chemical explosion at a tire manufacturing facility.

TCL Critical Task: Res.C1b 1.4.2 Develop medical mutual aid agreements for medical facilities and equipment. (TCL Page 496)

Scenario: (EE) Explosive Event

Tier: 3

Capability Element: (PER) Personnel

Project Name: Mutual Aid Agreements Effectiveness for Chemical Explosion

P/P# Res.C1b 1.4.2-EE-3-PER
> To determine the P/P number, use the following format:
> TCL Critical Task Number-Scenario abbreviation-Tier number-Capability Element abbreviation

Hospitals and EMS systems must meet the following requirements in order to receive FY 2006-2007 funding:

➢ Hospitals participating in the State Medical Asset Resource Tracking Tool (SMARTT).

➢ EMS Systems participating in PreMIS unless otherwise approved by NCOEMS.

➢ Hospitals and EMS systems participating in a minimum of 50% of their RAC Disaster Preparedness Committee (DPC) meetings in grant year 2005-2006.

➢ Hospitals participating in some capacity with the State Medical Assistance Team (SMAT) II program.

➢ Hospitals must be compliant with all audit reporting requirements. In accordance with GS143-6.2, funding will not be provided to hospitals listed by the State Controllers Office on the Suspension of Funding List.

➢ *Step 2*

Regional DPRGC submit final project recommendations to the RAC Hospital Preparedness Planner based on eligibility requirements.

➢ *Step 3*

Complete RAC grant application.

> ➢ Complete application cover sheet.

> ➢ Complete the Project Narrative Form for each of the projects selected. The Project Narrative will be the primary document used by NCOEMS in determining the fundability of a project. The Project Narrative will be used to complete the project objectives or produce deliverables and a budget detailing expenses.

The following are required for each Project Narrative Form:

Project Name

Project Coordinator (PC) & Contact information

Entity/Entities Receiving Funding & Project Coordinators

P/P #

Tier: 1, 2 or 3

Critical Task: Number and description of Critical Task

Scenario: Pandemic Influenza, Explosive Event or Inclement Weather

Capabilities Based Planning Element: Personnel, Planning, Equipment & Systems, Training or Exercise, Evaluation & Corrective Action.

Mission: A brief description of the mission that the project is intended to meet.

Objectives: A bulleted list of the objectives accomplished or the deliverables produced on completion of the project.

Narrative: A brief description of how the project will be accomplished. Included in the narrative should be how the TCL and the State and County HVAs and the HRSA 2005 – 2006 Survey will be used to close capability gaps. The goal of the narrative is to help program managers, reviewers, and other interested parties understand what the project does. The narrative must address:

1. That not only that the capability element and its associated components are eligible for funding but they must be clearly linked to a State or County HVA or HRSA Grant 2005 - 2006 Survey gap analysis to show that there is still an unmet need.
2. Each capability element and its associated components must be linked to the specific TCL's Critical Task that it is addressing
3. Each capability element and its associated components must be linked to the specific tier that it is addressing.

Performance Measures: Must show how the RAC will provide ongoing monitoring and reporting of project accomplishments, particularly progress towards completing the projects objectives or deliverables. The Performance Measures should identify measurable outcomes to include significant project milestones, completions dates and the associated Critical Task's Performance Measure.

➤ *Step 4*

Complete one Composite Budget Form summarizing total by Scenario and Tier. (See sample of NCOEMS HRSA Grant web page)

➢ *Step 5*

After application is completed, the Hospital Preparedness Planner shall contact their NC OEMS Regional Specialist to establish a meeting with NCOEMS representatives to complete the final review and approval of the application. Prior to this meeting, **TWO ORIGINAL** signed applications shall be complete. At the conclusion of this meeting, NCOEMS representatives will return to Raleigh with the approved **TWO ORIGINAL** signed applications for contract execution.

Steps 1 through 5 must be completed by November 9, 2006. No funds shall be expended until the contract has been fully executed.

During the term of the contract grantees must submit quarterly progress reports even if no activity has taken place. These reports can be submitted with the drawdown process. All expenditures must be completed by August 31, 2007. A final narrative, financial report and all final invoices must be submitted to the NCOEMS by September 30, 2007.

All grant contracts will expire on August 31, 2007.